INSTRUCTIONS FOR COMPLETEING THE HOME & COMMUNITY BASED CARE FOR THE ELDERLY /DISABLED TURNAROUND DOCUMENT (BILLING FORM)

These instructions are for completing the billing document necessary to obtain payment through the North Dakota Medicaid Program for the Medicaid Waivers, Medicaid State Plan Personal Care Services, Service Payments for the Elderly and Disabled (SPED) Program, and Expanded SPED Program. Payment is made for services provided to eligible clients. The local county social service office determines client eligibility.

YOU MAY ONLY BILL FOR SERVICES THAT YOU ACTUALLY PROVIDED AND THAT YOU ARE AUTHORIZED TO PROVIDE ON THE SFN 1699 AUTHORIZATION TO PROVIDE SERVICES FORM AND/OR THE SFN 663 AUTHORIZATION TO PROVIDE PERSONAL CARE. THE COUNTY CASE MANAGER SENDS THIS FORM TO YOU.

To ensure timely payment of claims, the turnaround document (billing form) should be submitted during the first few working days of the month following service delivery. Turnaround documents (billing forms) may only be submitted once a month and only after all services for the month have been provided.

The provider will receive a Remittance Advice (RA) each time a claim is processed. If payment is made, the check will be enclosed or directly deposited. When payment is not made as billed, the RA explains why the claim was reduced or denied. It will also contain information regarding the service provided.

If a claim or a portion of a claim was denied (no payment made) and the provider believes the action was wrong, re-bill for the denied claim or the portion that was denied. If the amount PAID was reduced from the billed amount and the provider believes the action was wrong, use SFN 639, Provider Request for an Adjustment, to make the corrections.

***** If you make a mistake while completing the fillable turnaround document simply tab to the error and type the information over.

To fill out the new turnaround document (billing form) complete the following:

- **Provider Information**

  A. **Provider ID** – Enter the five-digit provider number you were assigned.

  B. **Provider** - Enter your name. LAST NAME first, then the first name, and middle initial, if used.

  C. **Address**- Enter complete mailing address.

  D. **City / State / Zip** – Enter the city / state/ zip code

  E. **Authorization Period**-Enter the first day and the last day of the month for which payment is being claimed. *Use two digits for the month, two digits for the day and two*

digits for the year. For example the authorization billing period of December 2006 would be indicated as: 12/01/06 through 12/31/06.

- **Recipient (Client) Information**

A. **Recipient's (Client) Identification (ID) Number**- Enter the "Client (Recipient) Identification Number" as it appears on the Authorization to Provide Services.

B. **Recipient (Client) Name (Last, First, MI)**- Enter the LAST NAME, first name and middle initial of the recipient/client to whom service or care was provided. The recipient's name must be spelled the same as on the Authorization to Provide Services issued by the HCBS Case Manager.

- **A SEPARATE TURNAROUND DOCUMENT (BILLING FORM) MUST BE USED FOR EACH RECIPIENT (CLIENT) YOU ARE BILLING FOR.**

- **ONLY ONE MONTH OF SERVICE CAN BE BILLED ON EACH TURNAROUND DOCUMENT (BILLING FORM). THEREFORE, IF YOU ARE BILLING FOR SERVICES PROVIDED TO THE SAME PERSON DURING TWO (2) DIFFERENT MONTHS, IT WILL BE NECESSARY TO LIST THE RECIPIENT (CLIENT) ON TWO SEPARATE FORMS.**

- **Service (Billing) Data**

Note: If you are billing with a T1019 or T1020 billing code, these codes cannot be entered with any other procedure codes. For example, you cannot bill a T1019 and 00010 on the same form – you would need to use two forms. All other codes can be billed on one form if you are billing under the same recipient (client) ID number.

A. **Procedure Code**-Enter the Procedure Code for the service provided to the recipient (client) for the authorization period. All 5 boxes must be filled for example, 00010 is how you would bill for homemaker services.

Service provided in 15-minute billing units, such as homemaker service, must be billed for each day's occurrence. *{E.g., If homemaker service were provided to a recipient (client) on 10 different days during the month, it would be necessary to enter that procedure 10 times on the turnaround document (billing form).}* The form allows 18 entries per recipient (client) claim. If a recipient (client) received care on more than 18 days during the month, it will be necessary to use another form to enter the additional data. All client and provider information MUST BE re-entered on the second form. Do not staple the forms together.

Services billed at a DAILY rate, such as Family Home Care, can be billed as a single entry IF THERE WAS NO BREAK IN PROVIDING SERVICE DURING THE MONTH.

B. **From Day Through Day**-Enter the date(s) of service for each procedure code. If the service is paid in 15-minute units, enter the date/day the service was provided in both the "From day" and the "Through day" columns. If you are billing for a consecutive day service (has a daily unit rate), such as adult foster care, enter the

first day of service in the "From day" column and the last day of continuous service in the "Through day" column. *Enter the two-digit number that represents the day of the month being billed. {e.g., the day March 2 would be entered as "02".}*

C. **Units**-Enter the number of units you are billing for that day. The number of units is always given in a whole number with a zero (0) following the decimal point on the turnaround document (billing form). {*e.g., 3 units are entered as "3.0".}*

		3	.	0

D. **Billed Amount**- The billed amount equals the established rate set by the Department of Human Services for the provider for each procedure code multiplied by the number of units provided on that date.

The Medical Services Division issues a "provider profile" to each Qualified Service Provider giving the rate by procedure code.

- Sign and date the turnaround document (billing form). **You must make a copy for your records.**

MAIL COMPLETED TURNAROUND DOCUMENTS (BILLING FORMS) TO:

Department of Human Services
Medical Services Division
600 E Boulevard Ave Dept 325
Bismarck, ND 58505-0250

4910

North Dakota Department of Human Services

HOME & COMMUNITY BASED CARE FOR THE ELDERLY/DISABLED

Turnaround Document

Clear Fields

Provider ID:

Provider:

Address:

City State Zip:

Authorization Period:

M M / D D / Y Y

through

M M / D D / Y Y

Recipient ID Number - -

Recipient Name (Last, First, MI)

Procedure Code	From Day		Through Day	Units		Billed Amount	
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		TH		. 0		.	
		TH		. 0		.	
		TH		. 0		.	
		TH		. 0		.	
		TH		. 0		.	
		TH		. 0		.	
		TH		. 0		.	
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Providers: Retain a copy for your records.

Certification and Agreement of Providers: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and accept, as payment in full, the amounts paid, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws. That the services herein charged were actually rendered and were rendered under the conditions specified; and that no part of such bill, claim, account or demand has been paid. That the services provided and billed for qualify for federal participation under 42 USC 1396 (A) ET. SEQ. and that rules and regulations promulgated and adopted thereunder. I further certify that goods and services hereby designated are furnished without discrimination as to age, sex, race, color, national origin, political affiliation or handicap. I agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the state plan and to furnish the state agency with such information, regarding any payments claimed by such person or institution forproviding services under the state plan, as the state agency may from time to time request.

Provider Signature: _____ Date: _____